Washington State Health Care Authority
Public Employees Benefits Board

2015 Medical Benefits Cost Comparison

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB plans, and extended-network benefits for Group Health's consumer-directed health plan (CDHP). Some copays and coinsurance do not apply until after you have paid your annual deductible. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions.

Annual Costs	Group Health				Kaiser Permanente		Uniform Medical Plan[3]	
	Classic	Value	CDHP	CDHP Extended Network[2]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Medical deductible Applies to out-of-pocket limit	$250/person $750/family	$350/person $1,050/ family	$1,400/person $2,800/family*		$250/person $750/family	$1,400/ person $2,800/ family*	$250/person $750/family	$1,400/ person $2,800/ family*
Medical out-of-pocket limit[1] (See separate prescription drug out-of-pocket limit for UMP Classic.)	$2,000/person $4,000/family Your deductible, copays, and coinsurance for all covered services apply.		$5,100/person $10,200/family** Your deductible, copays, and coinsurance for all covered services apply.		$2,000/ person $4,000/family Your deductible, copays, and coinsurance for most covered services apply.	$4,200/ person $8,400/ family** Your deductible, copays, and coinsurance for most covered services apply.	$2,000/ person $4,000/ family Your medical deductible, copays, and coinsurance for most covered medical services apply.	$4,200/ person $8,400/ family** Your deductible and coinsurance for most covered services apply.
Prescription drug deductible	None	None	Prescription drug costs apply toward medical deductible.		Prescription drug costs apply toward medical deductible.		$100/person $300/family* (Tier 2 and 3 drugs only)	Prescription drug costs apply toward medical deductible.
Prescription drug out-of-pocket limit[1]	Prescription drug copays and coinsurance apply to the medical out-of-pocket limit.				Prescription drug copays apply to the medical out-of-pocket limit.		$2,000/ person Your prescription drug deductible, copays, and coinsurance for all covered prescription drugs apply.	Presciption coinsurance applies to the medical out-of-pocket limit.

*Must meet family medical or prescription drug deductible before plan pays benefits.

**Must meet family medical out-of-pocket limit before plan pays 100% for covered benefits.

(continued)

The information in this document is accurate at the time of printing. Contact the plans or review the certificate of coverage before making decisions.

To obtain this document in another format (such as Braille or audio), call 1-800-200-1004.
TTY users may call through the Washington Relay service by dialing 711.

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Benefits	Group Health				Kaiser Permanente		Uniform Medical Plan[3]	
	Classic	Value	CDHP	CDHP Extended Network[2]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Ambulance Air or ground, per trip	20%	20%	10%	30%	15%	15%	20%	20%
Diagnostic tests, laboratory, and x-rays	$0; MRI/ CT/PET scan $30	$0; MRI/ CT/PET scan $40	10%	30%	$10	15%	15%	15%
Durable medical equipment, supplies, and prosthetics	20%	20%	10%	30%	20%	20%	15%	15%
Emergency room (copay waived if admitted)	$250	$300	10%	10%	$75	15%	$75 copay + 15%	15%
Hearing Routine annual exam	$15	$20	10%	30%	$30	$30	$0	15%
Hardware	You pay any amount over $800 every 36 months after deductible has been met for hearing aid and rental/repair combined.							
Home health	$0	$0	10%	30%	15%	15%	15%	15%
Hospital services Inpatient	$150/day up to $750 maximum/ admission	$200/day up to $1,000 maximum/ admission	10%	30%	15%	15%	$200/day up to $600 maximum/ year per person + 15% professional fees	15%
Outpatient	$150	$200	10%	30%	15%	15%	15%	15%
Office visit								
Primary care	$15	$20	10%	30%	$20	$20	15%	15%
Urgent care	$15	$20	10%	30%	$40	$40	15%	15%
Specialist	$30	$40	10%	30%	$30	$30	15%	15%
Mental health	$15	$20	10%	30%	$20	$20	15%	15%
Chemotherapy	$15	$20	10%	30%	$0	$0	15%	15%
Radiation	$30	$40	10%	30%	$0	$0	15%	15%
Physical, occupational, and speech therapy (per-visit cost for 60 visits/ year combined)	$15	$20	10%	30%	$30	$30	15%	15%

[1] Premiums, charges for services in excess of a benefit, charges in excess of the plan's allowed amount, coinsurance for out-of-network providers (UMP), and charges for non-covered services do not apply to out-of-pocket limit[3]. Non-covered services include, but are not limited to, member costs above the vision and hearing aid hardware maximums.

[2] Group Health's CDHP Extended Network includes First Choice Health Network, First Health Network, and its affiliated providers, and any other licensed provider in the U.S.

[3] UMP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services plus any amount the provider charges over the allowed amount.

[4] Preventive care is not covered in Group Health's CDHP Extended Network except for routine mammography screening. Annual medical deductible and 30% coinsurance applies.

[5] Contact your plan about costs for children's vision care.

Benefits	Group Health				Kaiser Permanente		Uniform Medical Plan[3]	
	Classic	Value	CDHP	CDHP Extended Network[2]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Prescription drugs								
Retail pharmacy (up to a 30-day supply)								
Value tier	$5	$5	$5	$5	Does not apply	Does not apply	5% (up to $10/ 30-day supply)	
Tier 1	$20	$20	$20	$20	$15	$15	10% (up to $25/ 30-day supply)	
Tier 2	$40	$40	$40	$40	$30	$30	30% (up to $75/ 30-day supply)	15%
Tier 3	50% up to $250	50% up to $250	50% up to $250	50% up to $250	Does not apply	Does not apply	50% (up to $150 for specialty drugs; there is no per-prescription cost-limit for non-specialty Tier 3 drugs)	
Mail order (up to a 90-day supply)								
Value tier	$10	$10	$10	Does not apply	Does not apply	Does not apply	5% (up to $30/ 90-day supply)	
Tier 1	$40	$40	$40	Does not apply	$30	$30	10% (up to $75/ 90-day supply)	
Tier 2	$80	$80	$80	Does not apply	$60	$60	30% (up to $225/ 90-day supply)	15%
Tier 3	50% up to $750	50% up to $750	50% up to $750	Does not apply	Does not apply	Does not apply	50% (up to $150 for specialty drugs; there is no per-prescription cost-limit for non-specialty Tier 3 drugs)	
Preventive care	$0	$0	$0	Not covered[4]	$0	$0	$0	$0
See certificate of coverage or check with plan for full list of services.								
Spinal manipulations	$15	$20	10%	30%	$30	$30	15%	15%
Vision care[5] Exam (annual)	$15	$20	10%	30%	$20	$20	$0	$0
Glasses and contact lenses	You pay any amount over $150 every 24 months (or two calendar years for UMP) for frames, lenses, contacts, and fitting fees combined. **Exception:** For UMP Classic, you pay any amount over $65 for contact lens fitting fees.							

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**Must meet family medical out-of-pocket limit before plan pays 100% for covered benefits.